

BOARD OF NURSING FACULTY QUALIFICATIONS FORM

INSTITUTION: (check appropriate box)

- | | | |
|---|--|---|
| <input type="checkbox"/> MSU Bozeman BSN | <input type="checkbox"/> Carroll College BA | <input type="checkbox"/> Miles Comm. College AAS IN NURSING |
| <input type="checkbox"/> MSU-Northern ASN | <input type="checkbox"/> Salish Kootenai College RN AS | <input type="checkbox"/> U of M Butte – Division of Tech RN ADN |
| <input type="checkbox"/> Billings COT – MSU PN AAS | <input type="checkbox"/> Butte COT – U of M PN AAS | <input type="checkbox"/> Great Falls COT – MSU PN AAS |
| <input type="checkbox"/> Helena COT – U of M PN AAS | <input type="checkbox"/> Missoula COT – U of M PN | |

NAME: _____
Last first middle

ADDRESS: _____
 _____ Street or P.O. Box _____ city _____ state _____ zip _____

MONTANA LICENSE NUMBER: _____ **DATE OF APPOINTMENT:** _____

POSITION TITLE: (check appropriate box)

- ☐ Dean of Nursing
 ☐ Professor of Nursing
 ☐ Associate Professor of Nursing
☐ Assistant Professor of Nursing
 ☐ Clinical Instructor
 ☐ Other (specify: _____)

TEACHING RESPONSIBILITIES:

- ☐ Clinical Only ☐ Theory Only ☐ Clinical and Theory

AREA(S) OF TEACHING RESPONSIBILITIES: (check all that apply)

- ☐ Medical Surgical ☐ Obstetrics/Perinatal ☐ Mental Health
☐ Pediatrics ☐ Fundamentals of Nursing ☐ Adult Health
☐ Other: (Specify: _____)

ACADEMIC EDUCATION *: (in reverse chronological order)

SCHOOL NAME/LOCATION	Major	Minor	Years Attended	Year Grad.	Degree

* **Note:** If faculty member does not meet the Montana requirements for educational preparation, a written plan for meeting the requirements within the specified time frames must be signed and enclosed, along with a signature by the program director in the Education Waiver Section of this form. (MAR 8.32.1112 & MAR 8.32.1113)

PROFESSIONAL EDUCATION: ☐ No Courses Taken for College Credit; **or** complete section below

SCHOOL NAME/LOCATION	Name of Course	Year(s) Attended

PROFESSIONAL EXPERIENCE: (in reverse chronological order – add copies as necessary)

[illegible]

OTHER RELEVANT EDUCATION AND/OR EXPERIENCE TO SUPPORT FACULTY POSITION:

☐ Continuing professional education documents attached

Add others here as deemed appropriate:

SIGNATURES:

Faculty Member Signature

PRINT NAME HERE

Date _____

Nursing Department Head Signature

PRINT NAME HERE

Date _____

[illegible]**EDUCATION WAIVER STATEMENT:**

I am requesting an educational waiver for this faculty member and the three-year education plan is enclosed. I certify that no more than 10% or two faculty, whichever is greater based on total FTE, are on educational waiver at this time. I will notify the board with:

- education plan changes
- education plan completion
- progress toward education goal with the annual report, if plan not yet completed

Total FTEs: _____ **# on Waiver:** _____ **% on Waiver:** _____

Nursing Department Head Signature

PRINT NAME HERE

Date _____